Health Home Quality Improvement Workgroup - 3/30/2022

Participants

Pamela Lester IME	**Heidi Weaver IME**	**LeAnn Moskowitz IME**
Tami Lichtenberg IME	**David Klinkenborg AGP**	**Sara Hackbart AGP**
Tori Reicherts ITC	**Bill Ocker ITC**	**Flora Schmidt IBHA**
Susan Seehase IACP	**Kristi Oliver Children's Coalition**	Paula Motsinger IME
Stacy Nelson Waubonsie (90)	**Amy May Waubonsie**	**Geri Derner YSS**
Jen Cross Orchard Place	**Kim Keleher Plains**	**Andrea Lietz Plains**
Melissa Ahrens CSA	**Christina Smith CSA**	**Faith Houseman Hillcrest**
Ashley Deason Tanager	**Stephanie Millard First Resources**	**Kristine Karminski Abbe**
Shawna Kalous Plains	**Rich Whitaker Vera French (1hr)**	**Jamie Nowlin Vera French**
Crystal Hall Tanager (90)	**Brooke Johnson Abbe**	**Mike Hines Tanager**

Notes

Last meeting Notes:

- No questions/concerns from group.

Draft Workgroup Report:

- No Changes were made to report.

Provider Standards

- Principles:
  - How we believe drives what we do. That is why it is important to focus on the principles.
- Function:
  - We really want to set our principles, so we make decisions on that foundation
- Considerations:
  - How does the HH meet provider standards?

Brainstorming Activity:

- The SPA page 9 states “Integrated Health Home (IHH) will include, but not limited to meeting the following criteria:” Clarify by adding “one” “meeting one of the following criteria”

- With the workforce shortage, the inclusion of experience allowed in lieu of a degree is recommended to include a broader workforce. For example, chapter 24 allows the nurse to be the case manager as long as they have three years of experience.

- Add additional roles such as a CMA or LPN for tasks they may be able to do to take the load of the RN.

- Remove “Child” and “Adult” from nurse on page 16 of the SPA.

- Request time to unpack “Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.”

- Further research on “Complete status reports to document member's housing, legal, employment status, education, custody, etc.” so the group can discuss formal recommendations.

- Further discussion of HH role under whole person orientation.

- The group would like to clarify “receive” in the statement: “Work with LE or IME to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC)”

- The group recommends removing “agreements approved by the state” in the 2022 SPA on page 18 “Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State.”

- The group would like to understand what is meant by a licensed Health Care Provider. This will help understand then who can provide the services.

- The group asks if NCQA LTSS is a requirement.

- The group recommends simplifying and combining the requirement to “Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees”

- The group would like the bullet “Complete web-based member enrollment, disenrollment, members’ consent to release to information, and health risk questionnaires for all members” clarified.

- The group would like “evaluate” to be clarified on page 18 of the SPA “Monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services”

- Further discussion on HIT information on page 40 around HIT. How does Federal guidance and the SPA line up? What other things could be helpful for members? Does this include assisting them with the MCO portal or the PCP portal? Are there other ways to do this beyond the below bullet points? Who do we capture the intent that moves us forward and give space for the journey?
    - *Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time*
    - *Demonstrate evidence of acquisition, instillation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law*
    - *Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations*
    - *Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers*
- Further discussion on what the Lead Entity is responsible for (and how they support providers) and what the Health Home is responsible to then identify what would be missing.
- Further discussion on what to add to standards for ICM.

Next Steps:

Pam will create slide decks to address further discussion needs.

Workgroup will be ready to discuss more in detail.